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ABSTRACT

Alcoholic women living with their children are recognized as a treatment population needing special environmental support as part of their recovery. The Family Rehabilitation Coordinator Project is a pilot research and training effort to aid the recovery of alcoholic women and their children and families. Trainees work in the home of an alcoholic mother beginning her recovery through some recognized plan of treatment. Results presented focus on changes in relationships and roles within the family which may be related to the presence of the rehabilitation coordinator, particularly changes in the perceptions and behaviors of the recovering alcoholic mother. (Author)

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Recovery for the Alcoholic Mother and Family Through Home-Based Intervention

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The Family Rehabilitation Coordinator Project is an intensive six-month program of classroom instruction and assigned field experiences for persons who wish to provide support services in the homes of alcoholic mothers to assist them and their families through the recovery process. During the first project year just past, a training curriculum was written and tested in a pilot group of trainees.

Supported by a three-year grant from the National Institute on Alcohol Abuse and Alcoholism, U.S. Department of Health, Education and Welfare, 15 persons were selected for the traineeship positions and received a stipend of $300 per month during their training. The Health Sciences Department of UCLA Extension, under whom the project is conducted, has awarded 24 University Extension credits fot the training.

Trainees (who at the moment happen all to be women) are able to work fulltime (approximately 5 days/week, 8 hours/day) in the home of a family with an alcoholic mother who is beginning her recovery through some recognized plan of treatment. The goal is not to prescribe specific treatment for the woman, but to provide needed support for her and the family, to help prevent relapse and future problems in the children.

During the training period 14 trainees provided a minimum of 1 month to a maximum of 2 months' service to 16 families. The results of this training/service project are presented in this paper.

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Rationale of Home-Based Intervention

Help for Women and Children. Mothers, whether they are homemakers or workers, usually are the primary caregivers of their children. Thus, mothers have a tremendous impact on the lives of most children in this cociety. By giving aid to mothers and families with children living in the home, it is possible to set in motion practices which will promote the healthy growth and adjustment of those children. In addition, there are very few health care services that assist the woman with illness or emotional problems in coping with her childrearing responsiblities. The development of the Family Rehabilitation Coordinator role is intended to assist families with their child-rearing tasks.

It is hoped that the availability of assistance with children will enable mothers to seek treatment sooner. This may be an effective strategy for early recognition of problems with women and children leading to earlier intervention and resolution.

Delivering Care in the Home. In dealing with correcting behavior, it is important to observe and respond to the actual situation that causes problems. It is difficult to accurately assess a family's recovery plan in a hospital or office setting and impossible to to tell how well suggestions are being implemented. By going to the home, intervention can be immediate, appropriate and practical. Modeling of desired behaviors in parenting, relating skills and housework can be done in the actual setting where they are to be practiced. Working in the home has the potential of being a new effective therapeutic modality -- bringing care to the people, an ultimate outgrowth of community mental health.

Family Systems Modification. It is expected that recovery or improvement of any one member of a family depends on changes and adjustments in other family members. By observing the family system and intervening in a planned and controlled manner, family change can be channeled in the directions that will promote the most family and individual growth. Because the Family Coordinator is "inside" the family, the effect is of adding the strength of a stable adult to the system, giving the system more energy, flexibility and resilience to cope with the changes involved in growth toward healthy functioning.

The role of the Family Rehabilitation Coordinator (FRC) can conceptually be divided into two aspects--concrete and interpersonal. The concrete aspect is the activites, while the interpersonal aspect relates more to the purposefulness of the behaviors.

Primarily the Family Rehabilitation Coordinator role is aimed at that level of interaction with the family which will best link cognitive understanding with behavior. The emphasis was on behaving rather than discussing. Since the general goal was to facilitate the family behaviors much of the trainee activity served as a model for the family.

Preparation. The trainees were prepared to be involved in a wide range of activities within the family. The core curriculum addressed areas related to household management, family interaction, child development, modes of recovery, alcoholism, and community resources. The activities related to household management included shopping, meal planning, household chores and budgeting. Family interactional activities include planning recreation, coordinating household responsibilties and facilitating communication between family members. Developing age-appropriate activities, supervising the children in the parents' absence and modeling parenting techniques were the activities related to child devlopement. Providing information about alcoholism by discussion and suggested reading, accompanying the alcoholic mother or any family member to treatment resources, and investigating the community as to resources for medical, financial, recreational, educational and social support were all activities to be engaged in with the family by the trainee.

Field Implementation of the Role. The actual implementation of these activites within the client family reflects both the uniqueness of each family and the creativity of the trainees. Household management and actual chores were often the focus of complaint within the family. In one family the trainee helped to organize the children in their tasks by first involving them in drawing a chore chart and then actually assisting with

the chore; e.g., cleaning the bathroom or straightening up their bedroom. In another family of seven where dinner was chaotic at best, the trainee helped the mother plan meals that would be prepared in the morning thus leaving her freer to interact with the children. This plan helped her in the resumption of her parental role by allowing her a greater control over the situation and removing her 12 and 13 year-olds from the fixing of dinner. The kitchen and hallway floors got cleaned by one formerly irresponsible eleven-year-old when the trainee suggested that the floors were too dirty for them to play a game of jacks.

Meal planning, cooking and budgeting suddenly became of great importance to one family when the mother abandoned the teenage children to avoid a court hearing. The trainee was able to introduce inexpensive, simple casseroles into their diet by teaching the oldest girl to cook and shop frugally.

Facilitating family interaction was an area of significant focus. The trainee would first model that talking problems through was possible and then would encourage the family members (parent-child or siblings) to sit down and discuss what bothered them. One young daughter was encouraged to write a letter to her mother about a complaint rather than sniping at her all day. The trainees encouraged cooperative behavior between siblings by actively listening to each and suggesting ways to negotiate with each other. A sixteen-year-old girl was encouraged to ask her 5-year-old cousin to help rather than telling her.

The mothers were often at a loss for alternative ways of interacting with their children. Sometimes they needed the opportunity to interact with the children as individuals. One mother was able to spend individual time after the trainee agreed to supervise the remaining children. The trainees also developed activities that both parent and child could engage in besides shopping or watching T.V. One young boy wanted to improve his handwriting. He agreed to work with the trainee several times a week. The trainee would write a short paragraph and he would copy it to practice his handwriting. After a while the mother took over the paragraph writing. She experienced being helpful to her son and he got her positive undivided attention.

Families were encouraged to explore their own resources in seeking recreation. The trainee would ask one of the children to show her the local park or library and explore what activities went on. The parents were encouraged to enroll the children in activities with other children. The mothers were supported in their recreational activities like learning to macrame or taking an exercise class. The trainee would provide information and/or support to facilitate the mother's efforts.

Some women needed to either become involved with a recovery program or increase their involvement. The trainee would help her explore the alternatives in her area and sometimes accompany her to meetings. Mothers would be encouraged to call their Alcoholics Anonymous sponsors or counselors when it was appropriate and actively involve themselves with their treatment plan. The trainee would also discuss the mother with the sponsor or counselor (with written consent) and assist in implementing their advisements. Other professionals, such as probation officers, social workers, pyschologists, were also contacted (again with written consent) by the trainee.

At times the trainee would act as an advocate of the family. In developing a budget with one mother, the trainee found the utility payments were in arrears and the mother could not afford to pay immediately. After developing a schedule of payments the trainee contacted one utility company requesting an extension. After one extension was obtained, the trainee rehearsed the next phone call with the mother who then became her own advocate with the next utility company.

Evaluation

The evaluation is designed to cover both outcome and process variables. The method used to obtain basic outcome data was to conduct structured interviews with each responsible family member at the conclusion of the trainee placement and again at six months after the placement. The interviewer scheduled the interviews and presented herself to the family members as an independent evaluator. By this means as well as guarantees of confidentiality, it is hoped that the interview results provide valid expressions of the usefulness of the Family Rehabilitation Coordinator trainee to the family.

Interviews were also conducted with each of the trainees. These interviews focused on family change variables and also on the training program, including the cirriculum and the field experiences.

The trainees mentioned a variety of things they considered positive about their family training experience, most frequently mentioning establishing relationships with the family members, particularly the mother. The most frequently suggested improvement for the client family training was to have more field experiences or short placements before going into the client family.

Follow-Up Family Interviews. The primary question in the evaluation is whether the Family Rehabilitation Coordinator would have a positive effect on the family of the alcoholic mother or the mother herself. The method used to address this question has been to interview the mother and additional family members. The areas covered by these interviews were parallel in part with those on the trainee interviews, with the intent to crosscheck the family responses with those of the trainee. The areas covered in the interviews included:

Tasks performed by the Family Rehabilitation Coordinator

Changes in household management

Taking care of children

Mother-child relationships

Mother-spouse relationships

Involvement in therapeutic process

Family Rehabilitation Coordinator's effect on mother's drinking

Crisis intervention

Family Planning

The two-month family placement for the trainees was delayed beyond the orginally planned time. For this reason as well as some additional delay caused by difficulties in scheduling family members for two to three hour interviews have not been completed at the time of writing of this report. Perforce, analysis of the data have also not been accomplished. A separate evaluation report will present this aspect of the evaluation along with more complete results from other aspects of the evaluator. Limitations in the design of the evaluation are the lack of a matched family control group and the small number of families and trainees (N =15). Nevertheless, the authors believe that even these necessarily incomplete and preliminary data will be of interest and importance.

Interview Results

Interviews were conducted with 11 of the first 14 client camilies. The mother of one of these families was not available. The results reported here are from interviews with ten mothers.

Family Rehabilitation Coordinator and Mother's Therapy. All of these mothers reported that Alcoholics Anonymous was their primary alcoholism treatment. One mother also attended group therapy at an alcoholism agency. All ten stated that they discussed their "treatment," i.e., Alcoholics Anonymous, with the trainee. All but two mothers found these discussions helpful. When asked what aspects of their treatment they discussed with the trainee, these ten mothers gave 25 responses which were distributed as shown:

Aspects of alcoholism treatment mothers discussed with FRC

Information obtained about alcoholism	3
How treatment made mother feel about alcoholism	4
Insights gained about self	4
Whether treatment was helpful	7
How treatment made mother feel about self	7

Given that the treatment method of all of these mothers was Alcoholics Anonymous, it is not surprising that the most frequently mentioned topics of discussion were how treatment made them feel about themselves and whether Alcoholics Anonymous was helpful.

Three of the mothers reported that they drank, less than 5 times, while the trainee was working with them. None of these "drinkers" thought there was anything the trainee could have done to keep them from drinking. At the same time four of the seven "non-drinkers" reported that the trainee helped them not to drink, primarily by being supportive to them.

FRC assistance with household management. Of these ten women, a high proportion - seven - reported that they changed various aspects of the way they ran their households while the trainee was working with them. Since the training curriculum included various units on these areas because of the hypothesized disruption in the alcoholics household, these results are important since they demonstrate a definable area in which a specially trained agent can be of both needed and visible assistance to the family which is dealing with the tensions and uncertainties of the recovery process.

The areas in which the mothers reported that they changed their household management methods were:

Meal Planning	6 responses
Preparing meals	3 "
Marketing	4 "
Budgeting	5 "
Housework and Laundry	4 "

The trainee and the children. The trainee helped with the children of all ten mothers interviewed. In addition to providing basic baby sitting and general child care, the mothers also indicated that the trainees talked to the children, helped them with their school work, and obtained information about outside activities and community resources for children.

The mothers were also asked to rate their relationship with their children before and after the trainee was with the family. Two mothers rated their relationship with their children as "excellent" both before and after the trainee and one mother was no

longer with her children. Six of the remaining seven reported improvement in these relationships.

Summary. The mothers were asked to tell the interviewer what they liked most and what they liked least about having the trainee in their homes. Most of the mothers stated that the best thing about having the trainee in the home was having someone there to talk to. Six of the mothers had nothing negative to say at all and the other negative comments related to early concerns about feeling the trainee to be an intrusion in their home.

The data reported here are preliminary and incomplete. There is no question, however, that the results from ten interviews with client-family mothers provide strong positive support for both the concept and the initial implementation of the Family Rehabilitation Coordinator program.

Replication. It is planned to use the planning, organization, materials and techniques of the project to establish similar training programs across the country. Every effort will be made to share information and experience with people and groups interested in using this approach.

The staff of the Family Rehabilitation Coordinator Project welcomes inquiries and contact from others in the field interested in women, children and family work.